Senate Bill No. 643

CHAPTER 551

An act to amend Sections 4688.5 and 14043.26 of, and to add Section 14132.99 to, the Welfare and Institutions Code, relating to health care.

[Approved by Governor October 5, 2005. Filed with Secretary of State October 5, 2005.]

LEGISLATIVE COUNSEL'S DIGEST

SB 643, Chesbro. Nursing facilities.

(1) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, and which provides health care services to qualified low-income recipients. The Medi-Cal program is partially governed and funded by federal Medicaid provisions.

Under existing law, the State Department of Health Services has obtained various waivers of Medicaid provisions generally aimed at enabling more Medi-Cal recipients to obtain the necessary services to reside in community settings.

This bill would authorize the department to seek an increase in the scope of these waivers, in order to enable additional nursing facility residents to transition into the community, but would condition implementation of these amended waivers upon obtaining federal financial participation, and only to the extent it can demonstrate fiscal neutrality within the overall department budget.

Existing law provides for the payment of claims for providers of services under the Medi-Cal system.

This bill would require the department, upon receipt of a complete and accurate claim for an individual nurse provider, as defined, to adjudicate the claim within an average of 30 days.

Existing law contains application procedures for the approval and enrollment of Medi-Cal providers.

This bill would require the department, during the budget proceedings of the 2006-07 fiscal year, and each fiscal year thereafter, to provide data to the Legislature specifying the timeframe under which it has processed and approved the provider applications submitted by individual nurse providers, as defined.

(2) Existing law authorizes the State Department of Developmental Services to approve a regional center proposal to provide for housing for persons eligible for regional center services.

This bill would clarify that the proposal would ensure full payment of leases, and would be based on the availability for occupancy.

The people of the State of California do enact as follows:

SECTION 1. Section 4688.5 of the Welfare and Institutions Code is amended to read:

4688.5. (a) Notwithstanding any other provision of law to the contrary, the department may approve a proposal or proposals by Golden Gate Regional Center, Regional Center of the East Bay, and San Andreas Regional Center to provide for, secure, and assure the full payment of a lease or leases on housing, developed pursuant to this section, based on the availability for occupancy in each home, if all of the following conditions are met:

(1) The acquired or developed real property is available for occupancy by individuals eligible for regional center services and is integrated with housing for people without disabilities.

(2) The regional center has approved the proposed ownership entity, management entity, and developer or development entity for each project, and, prior to granting the approval, has consulted with the department and has provided to the department a proposal that includes the credentials of the proposed entities.

(3) The costs associated with the proposal are reasonable.

(4) The proposal includes a plan for a transfer at a time certain of the real property's ownership to a nonprofit entity to be approved by the regional center.

(b) Prior to approving a regional center proposal pursuant to subdivision (a), the department, in consultation with the California Housing Finance Agency and the Department of Housing and Community Development shall review all of the following:

(1) The terms and conditions of the financing structure for acquisition and/or development of the real property.

(2) Any and all agreements that govern the real property's ownership, occupancy, maintenance, management, and operation, to ensure that the use of the property is maintained for the benefit of persons with developmental disabilities.

(c) No sale encumbrance, hypothecation, assignment, refinancing, pledge, conveyance, exchange or transfer in any other form of the real property, or of any of its interest therein, shall occur without the prior written approval of the department and the Health and Human Services Agency.

(d) Notice of the restrictions pursuant to this section shall be recorded against the acquired or developed real property subject to this section.

(e) At least 45 days prior to granting approval under subdivision (c), the department shall provide notice to the chairs and vice chairs of the fiscal committees of the Assembly and the Senate, the Secretary of the Health and Human Services Agency, and the Director of Finance.

(f) The regional center shall not be eligible to acquire or develop real property for the purpose of residential housing.

SEC. 2. Section 14043.26 of the Welfare and Institutions Code is amended to read:

14043.26. (a) (1) On and after January 1, 2004, an applicant that is not currently enrolled in the Medi-Cal program, or a provider applying for continued enrollment, upon written notification from the department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location.

(2) Clinics licensed by the department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(3) Health facilities licensed by the department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(4) Adult day health care providers licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(5) Home health agencies licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(6) Hospices licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(b) Within 30 days after receiving an application package submitted pursuant to subdivision (a), the department shall provide written notice that the application package has been received and, if applicable, that there is a moratorium on the enrollment of providers in the specific provider of service category or subgroup of the category to which the applicant or provider belongs. This moratorium shall bar further processing of the application package.

(c) (1) If the applicant package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria listed in paragraph (2), the applicant or provider shall be considered a preferred provider and shall be granted preferred provisional provider status pursuant to this section and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a preferred provider and the criteria necessary for the consideration shall be publicized to all applicants and providers. An

applicant or provider who desires consideration as a preferred provider pursuant to this subdivision shall request consideration from the department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin. Request for consideration as a preferred provider shall be made with each application package submitted in order for the department to grant the consideration. An applicant or provider who requests consideration as a preferred provider shall be notified within 90 days whether the applicant or provider meets or does not meet the criteria listed in paragraph (2). If an applicant or provider is notified that the applicant or provider does not meet the criteria for a preferred provider, the application package submitted shall be processed in accordance with the remainder of this section.

(2) To be considered a preferred provider, the applicant or provider shall meet all of the following criteria:

(A) Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which license shall not have been revoked, whether stayed or not, suspended, placed on probation, or subject to other limitation.

(B) Be a current faculty member of a teaching hospital or a children's hospital, as defined in Section 10727, accredited by the Joint Commission for Accreditation of Healthcare Organizations or the American Osteopathic Association, or be credentialed by a health care service plan that is licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code; the Knox-Keene Act) or county organized health system, or be a current member in good standing of a group that is credentialed by a health care service plan that is licensed under the Knox-Keene Act.

(C) Have full, current, unrevoked, and unsuspended privileges at a Joint Commission for Accreditation of Healthcare Organizations or American Osteopathic Association accredited general acute care hospital.

(D) Not have any adverse entries in the Healthcare Integrity and Protection Databank.

(3) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in paragraph (2) are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders to identify similar criteria for other providers so that they may be considered as preferred providers.

(d) Within 180 days after receiving an application package submitted pursuant to subdivision (a), or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider under subdivision (c), the department shall give written notice to the applicant or provider that any of the following applies, or shall on the 181st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 181st day:

(1) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(2) The application package is incomplete. The notice shall identify any additional information or documentation that is needed to complete the application package.

(3) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7, and is conducting background checks, preenrollment inspections, or unannounced visits.

(4) The application package is denied for any of the following reasons:

(A) Pursuant to Section 14043.2 or 14043.36.

(B) For lack of a license necessary to perform the health care services or to provide the goods, supplies, or merchandise directly or indirectly to a Medi-Cal beneficiary, within the applicable provider of service category or subgroup of that category.

(C) The period of time during which an applicant or provider has been barred from reapplying has not passed.

(D) For other stated reasons authorized by law.

(e) (1) If the application package that was noticed as incomplete under subdivision (d) is resubmitted with all requested information and documentation, and received by the department within 35 days of the date on the notice, the department shall, within 60 days of the resubmission, send a notice that any of the following applies:

(A) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) The application package is denied for any other reasons provided for in paragraph (4) of subdivision (d).

(C) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(2) (A) If the application package that was noticed as incomplete under paragraph (2) of subdivision (d) is not resubmitted with all requested information and documentation and received by the department within 35 days of the date on the notice, the application package shall be denied by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to resubmit is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program.

(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider may not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(f) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspections, or unannounced visit of either of the following:

(A) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider may not reapply for three years.

(g) If provisional provider status or preferred provisional provider status is granted pursuant to this section, a separate provider number shall be issued for each location for which an application package has been approved. This separate provider number shall be used exclusively for the location for which it is issued, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the provider's business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(h) Except for providers subject to subdivision (c) of Section 14043.47, a provider currently enrolled in the Medi-Cal program at one or more locations who has submitted an application package for enrollment at a new location or a change in location pursuant to subdivision (a) may continue to submit claims under an existing provider number for services rendered at the new location until the application package is approved or denied under this section, and shall not be subject, during that period, to deactivation of the provider's provider number, or be subject to any delay or nonpayment of claims as a result of the use of the existing provider number for services rendered at the new location as herein authorized. However, the provider shall be considered during that period to have been

granted provisional provider status or preferred provisional provider status and be subject to termination of that status pursuant to Section 14043.27. A provider that is subject to subdivision (c) of Section 14043.47 may come within the scope of this subdivision upon submitting documentation in the application package that identifies the physician providing supervision for every three locations.

(i) An applicant or a provider whose application for enrollment, continued enrollment, or a new location or change in location has been denied pursuant to this section, may appeal the denial in accordance with Section 14043.65.

(j) (1) Upon receipt of a complete and accurate claim for an individual nurse provider, the department shall adjudicate the claim within an average of 30 days.

(2) During the budget proceedings of the 2006-07 fiscal year, and each fiscal year thereafter, the department shall provide data to the Legislature specifying the timeframe under which it has processed and approved the provider applications submitted by individual nurse providers.

(3) For purposes of this subdivision, "individual nurse providers" are providers authorized under certain home- and community-based waivers and under the state plan to provide nursing services to Medi-Cal recipients in the recipients' own homes rather than in institutional settings.

SEC. 3. Section 14132.99 is added to the Welfare and Institutions Code, to read:

14132.99. (a) For the purposes of this section, "facility residents" means individuals who are currently residing in a nursing facility and whose care is paid for by Medi-Cal either with or without a share of cost. The term "facility residents" also includes individuals who are hospitalized and who are or will be waiting for transfer to a nursing facility.

(b) An additional 500 slots beyond those currently authorized for the home- and community-based Level A/B nursing facility waiver shall be added and 250 of these slots shall be reserved for residents residing in facilities and transitioning out of facilities.

(c) For those patients who are in acute care hospitals and who are pending placement in a nursing facility, the department shall expedite the processing of waiver applications in order to divert hospital discharges from nursing facilities into the community.

(d) The nursing facility Level A/B waivers shall be amended to add the following services:

(1) One-time community transition services as defined and allowed by the federal Centers for Medicare and Medicaid Services, including, but not limited to, security deposits that are required to obtain a lease on an apartment or home, essential furnishings, and moving expenses required to occupy and use a community domicile, set-up fees, or deposits for utility or service access, including, but not limited to, telephone, electricity, and heating, and health and safety assurances, including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy. These costs shall not exceed five thousand dollars ($5,000).

(2) Habilitation services, as defined in Section 1915(c)(5) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)(5)), and in attachment 3-d to the July 25, 2003, State Medicaid Directors Letter re Olmstead Update No. 3, to mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings.

(e) When requesting the renewal of the waiver, the department shall consider expanding the number of waiver slots. Prior to submission of the waiver renewal request, the department shall notify the appropriate fiscal and policy committees of the Legislature of the number of waiver slots included in the waiver renewal request along with supportive data for those slots.

(f) The department shall implement this section only to the extent it can demonstrate fiscal neutrality within the overall department budget, and federal fiscal neutrality as required under the terms of the federal waiver, and only if the department has obtained the necessary approvals and receives federal financial participation from the federal Centers for Medicare and Medicaid Services. Contingent upon federal approval of the waiver expansion, implementation shall commence within six months of the department receiving authorization for the necessary resources to provide the services to additional waiver participants.

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